Table 1: Preventing venous thromboembolic disease in patients undergoing elective hip and knee arthroplasty: Clinical practice guideline of recommendations

Recommendation	Grade of recommendation
1. We recommend against routine postoperative duplex ultrasonography screening of patients who undergo elective hip or knee arthroplasty.	Strong
2. Patients undergoing elective hip or knee arthroplasty are already at high risk for venous thromboembolism (VTE). The practitioner might further assess the risk of VTE by determining whether these patients had a previous VTE.	Weak
Current evidence is not clear about whether factors other than a history of previous VTE increase the risk of VTE in patients undergoing elective hip or knee arthroplasty and, therefore, we cannot recommend for or against routinely assessing these patients for these factors.	Inconclusive
3. Patients undergoing elective hip or knee arthroplasty are at risk for bleeding and bleeding-associated complications. In the absence of reliable evidence, it is the opinion of this work group that patients be assessed for known bleeding disorders like hemophilia and for the presence of active liver disease, which further increase the risk for bleeding and bleeding-associated complications.	Consensus
Current evidence is not clear about whether factors other than the presence of a known bleeding disorder or active liver disease increase the chance of bleeding in these patients and, therefore, we are unable to recommend for or against using them to assess a patient's risk of bleeding.	Inconclusive
4. We suggest that patients discontinue antiplatelet agents (eg, aspirin, clopidogrel) before undergoing elective hip or knee arthroplasty.	Moderate
5. We suggest the use of pharmacologic agents and/or mechanical compressive devices for the prevention of VTE in patients undergoing elective hip or knee arthroplasty and who are not at elevated risk beyond that of the surgery itself for VTE or bleeding.	Moderate
Current evidence is unclear about which prophylactic strategy (or strategies) is/are optimal or suboptimal. Therefore, we are unable to recommend for or against specific prophylactics in these patients.	Inconclusive
In the absence of reliable evidence about how long to employ these prophylactic strategies, it is the opinion of this work group that patients and physicians discuss the duration of prophylaxis.	Consensus
6. In the absence of reliable evidence, it is the opinion of this work group that patients undergoing elective hip or knee arthroplasty, and who have also had a previous VTE, receive pharmacologic prophylaxis and mechanical compressive devices.	Consensus
7. In the absence of reliable evidence, it is the opinion of this work group that patients undergoing elective hip or knee arthroplasty, and who also have a known bleeding disorder (eg, hemophilia) and/or active liver disease, use mechanical compressive devices for preventing VTE.	Consensus
8. In the absence of reliable evidence, it is the opinion of this work group that patients undergo early mobilization following elective hip and knee arthroplasty. Early mobilization is of low cost, minimal risk to the patient, and consistent with current practice.	Consensus
9. We suggest the use of neuraxial (such as intrathecal, epidural, and spinal) anesthesia for patients undergoing elective hip or knee arthroplasty to help limit blood loss, even though evidence suggests that neuraxial anesthesia does not affect the occurrence of venous thromboembolic disease.	Moderate
10. Current evidence does not provide clear guidance about whether inferior vena cava filters prevent pulmonary embolism in patients undergoing elective hip and knee arthroplasty who also have a contraindication to chemoprophylaxis and/or known residual venous thromboembolic disease. Therefore, we are unable to recommend for or against the use of such filters.	Inconclusive